

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES		1. TRANSMITTAL NUMBER <u>04 - 001</u>	2. STATE <u>INDIANA</u>
		3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE & MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES		4. PROPOSED EFFECTIVE DATE <u>3/15/04</u>	
5. TYPE OF PLAN MATERIAL (Check One) <input type="checkbox"/> NEW STATE PLAN <input type="checkbox"/> AMENDMENT TO BE CONSIDERED AS NEW PLAN <input checked="" type="checkbox"/> AMENDMENT			
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate transmittal for each amendment)			
6. FEDERAL STATUTE/REGULATION CITATION <u>42 CFR 447.50</u>		7. FEDERAL BUDGET IMPACT a. FFY <u>2004</u> (\$ <u>2,277,165</u>) b. FFY <u>2005</u> (\$ <u>5,411,570</u>)	
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT <u>Attachment 4.18-A, page 1</u>		9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable) <u>Attachment 4.18-A, page 1</u>	
10. SUBJECT OF AMENDMENT <u>pharmacy copayment change</u>			
11. GOVERNOR'S REVIEW (Check One) <input type="checkbox"/> GOVERNOR'S OFFICE REPORTED NO COMMENT <input type="checkbox"/> OTHER, AS SPECIFIED <input type="checkbox"/> COMMENTS OF GOVERNOR'S OFFICE ENCLOSED <input type="checkbox"/> NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL			
12. SIGNATURE OF STATE AGENCY OFFICIAL <u>Melanie Bella</u>		16. RETURN TO <u>MELANIE BELLA</u> Asst. Secretary Office of Medicaid Policy & Planning 402 W. WASHINGTON St., RM W382 INDPLS., IN 46204 ATTN: T. BRUNNER, PLAN COORDINATOR	
13. TYPED NAME <u>MELANIE BELLA</u>			
14. TITLE <u>ASST. SECRETARY, OMPP</u>			
15. DATE SUBMITTED			
FOR REGIONAL OFFICE USE ONLY			
17. DATE RECEIVED <u>1/21/04</u>		18. DATE APPROVED <u>2/5/04</u>	
PLAN APPROVED - ONE COPY ATTACHED			
19. EFFECTIVE DATE OF APPROVED MATERIAL		20. SIGNATURE OF REGIONAL OFFICIAL <u>Cheryl A. Harris</u>	
21. TYPED NAME <u>Cheryl A. Harris</u>		22. TITLE <u>Associate Regional Administrator</u> <u>Division of Medicaid and Children's Health</u>	
23. REMARKS			

RECEIVED

JAN 21 2004

DMCH - IMM/MIN/VOL

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State of Indiana

A. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type of Charge		Amount and Basis for Determination
	Deductible	Coinsurance	
Transportation		X	\$0.50 for transportation services for which Medicaid pays \$10.00 or less
			\$1.00 for transportation services for which Medicaid pays \$10.01 to \$50.00
			\$2.00 for transportation services for which Medicaid pays \$50.01 or more
Pharmacy		X	\$3.00 for each covered drug dispensed.
Emergency Room		X	\$3.00 for nonemergency services (procedures billed outside a designated emergency procedure code range) when provided in a hospital emergency room

TN No. 04-001
Supersedes
TN No. 02-006

Approval Date FEB 03 2004

Effective Date March 15, 2004